St. Claire

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Please fax completed form to UKSC Health Information Management at 606-783-6369.

Patient Name: _____ Medical Record #: _____

Date of Birth: _____ Phone Number: _____ Social Security #:_____

1. I hereby authorize ☐ UK St. Claire OR ☐ _____ to disclose the health information, as described below, of the above-named patient to:

Name _____
Address _____
City, State, ZIP _____

2. REASON FOR REQUEST

_____ Personal interest _____ Legal claim processing _____ Insurance claim processing
_____ Continuity of care _____ Social Security or Disability claim _____ Other (Specify) _____

3. THE TYPE AND AMOUNT OF INFORMATION TO BE USED OR DISCLOSED IS AS FOLLOWS: (include dates where appropriate)

_____ Entire Medical Record _____ Face Sheet _____ Emergency Room Record
_____ Pathology Report _____ Discharge Summary _____ Operative Report
_____ History and Physical _____ Psychotherapy Records
_____ Radiology Report (Specify/Test/Date) _____
_____ Laboratory Reports (Specify/Test/Date) _____
_____ Other (Specify) _____

Related to services provided during the following period of time: _____

Information to be excluded from this authorization: _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), or records from other healthcare providers. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse. Initials: _____

4. THE PATIENT OR THE PATIENT'S REPRESENTATIVE MUST READ THE FOLLOWING STATEMENTS:

A. I understand that this authorization will expire: ☐ 60 days from date of signature; or

☐ upon the happening of the following events: _____

B. I understand that I may revoke this authorization at any time. I also understand the Notice of Privacy Practices explains how I may revoke my authorization.
C. I understand that authorizing the disclosure of this health information is voluntary, that I may refuse to sign this authorization and that I do not need to sign this form in order to ensure treatment.
D. I understand that pursuant to KRS 304.17a-555-Patient's Rights of Privacy Regarding Mental Health or Chemical Dependency, my health information used under this authorization may not be shared again by the recipient of the information beyond the purpose of this authorization, without written consent to the redisclosure.
E. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure by the recipient and may no longer be protected by federal confidentiality rules.

5. I understand there may be a charge for this request and that I will be notified of the cost before any charges are incurred.

6. RECORDS ARE ROUTINELY MAILED. PERSONAL ID IS REQUIRED WHEN RECORDS ARE PICKED UP. (1 photo ID or 2 other forms of ID).

_____ Social Security Card _____ School/Work ID
_____ Drivers License _____ Other (Specify) _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
If Signed by Legal Representative, Relationship to Patient Signature of Witness

The authorization must be signed by the patient if 18 years of age or over, or by a minor (under 18) if emancipated or otherwise eligible pursuant to KRS 214.185, or by the parent or legal guardian for any other minor or by patient's representative (i.e., power-of-attorney); or if the patient is deceased, by the executor or administrator. An order or letter of approval from the court is needed as proof for executor or administrator and a written document is needed as proof of power-of-attorney.